

Combining choice, quality and equity in social services

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1. Challenges in the field of social services

The population in Spain continues to grow, mainly as a result of migratory flows. In 2007, 15,1% of the population aged 15-64 had a foreign background, of which 4% were EU25 and 11.1% third country nationals.

Spain will have to deal with the effects of an ageing society (17% of a total population of more than 46 million is over 65). The projections show a significant rise in the old-age dependency ratio (24.1% in 2008, 24.45% in 2010 and 58.7% in 2050). Life expectancy at birth remained among the EU's highest in 2006 (men : 77.7%, women : 84.4)

Social expenditure as a percentage of GDP continues to be significantly below the EU average (20.9% in 2006, EU : 26.9%). Old age and survivor benefits accounted for 8.4% of GDP.

The accumulation of funds due to surpluses in the social security system (5.32% of GDP in 2008) is projected to last until 2023, an increase of 8 years compared to the projection made in 2005. From 2023 until 2029 the reserve fund will compensate unbalances on income. Despite this « time bonus », the process of reforms in the public pension system must continue, since public finances will be under great pressure because spending is expected to increase from 8.6% of GDP in 2004 to 15.7% in 2050.

Measures already adopted and changes made to the system raised the standard of living for pensioners, improved and rationalised certain schemes and the conditions for accessing pension benefits have encouraged more people to work longer.

2. Elderly

2.1. Pensions

The Spanish pension system relies on public earnings-related schemes (mandatory) financed by social contributions from workers (4.7% of earnings) and employers (23.6% of earnings). Pensions are calculated on the basis of revenue earned in the last 15 years before retirement and are adjusted annually in line with the consumer price index. Employees can extend their working career beyond the 65-year limit through, for example, part-time contracts or incentives to access retirement beyond 65. Early-retirement is possible from the age of 61. The relative median income ratio of people aged over 65 in 2007 was 0.76 (EU. 0.82)

Private pension plans are voluntary and cover both individual and occupational pension funds. In 2006 nearly 9.8 million people were covered by private pension plans (8 million people covered by individual plans)

The social security system was recently reformed through several legislative initiatives. Law 40/2007, which establishes longer minimum periods of contributions taking into account only the actual days of contribution, toughens the requirements for early retirement, applies effective controls to avoid fraud in incapacity protection, changes death and survival benefits and introduces new incentives to extend working lives. There is also a move to simplify the Social Security System integrating all schemes in the General Scheme and the Self-employed Scheme, in order to secure enough contributions for adequate pensions. Law 20/2007 brings social protection of self-employed-workers and salaried workers close. Lastly, Organic Law including the new paternity benefit.

Minimum contributory pensions have income guaranteed by a « top -up » benefit and amount to €7997/year in 2008 for those over 65 years or plus (€9222 for 65+with a dependant spouse), representing 27% of the total number of pensions .

Non-contributory pensions and other means-tested welfare pensions act as basic universal provision, covering 11.4% of pensioners.

2.2 Healthcare

The National Health System (NHS), defined as a mix of central government and regional government services, provides universal coverage. It is a decentralised system under which 17 autonomous regions run healthcare services, the Ministry of Health monitors and ensures the equity of the system and the Interterritorial Council of the NHS has a coordination role. Primary health care (PHC) is publicly managed and delivered in health centres. Patients register with a general practitioner (GP). GPs refer patients to specialists. Who refer then to hospital care. Outpatient ambulatory centres provide outpatient specialist care, an in-patient care is provided in hospitals which are publicly owned. It is a tax-based system, free at the point of access. Co-payments apply to pharmaceuticals except for retired and disabled people.

Patients can choose their GP within their area of residence. Private voluntary supplementary insurance covers 4.7% of the population. Civil servants can choose from three publicly funded mutual funds (70% state funding and 30% contributions) and either public or private provision. In June 2008 a major Pact for Health was signed by the Ministry of Health and all autonomous regions in the Inter-territorial Council with the aim of reinforcing the NHS. This agreement addresses crucial issues, such as improving human resources policy ; creating a common portfolio of services ; designating services and reference units ; rationalising healthcare spending ; establishing a common vaccination calendar ; fixing a maximum waiting time guarantee ; increasing the quality and facilitating innovation in health services ; facilitating universal access to palliative care ; boosting preventive care and implementing policies to counter illicit drug consumption.

2.3 Long-term care

Traditionally the family has the main role in care giving, but socio-demographic changes are making the provision of long-term care services and ever more pressing concern for the authorities. Demand for long-term care has increased in Spain as a result of the growing number of people over 65 years of age, the higher survival rate of the chronically ill, changes in the structure of families and the entry of women into the labour market. Hence, various laws have extended the range of services in this area over the past decade. The now include : PHC at home, day centres, temporary stays in residential homes, residential homes, telecare and financial aid to dependents and carers.

A new Law on the Promotion of Personal Autonomy and Care for People in a situation of Dependency was approved in December 2006. This new Law created the Autonomy and Dependency Care System (SAAD), designed to increase coverage to all people in a situation of dependency (from disabled children to adults to the dependent elderly, some 1 300 000 people) by 2015 through a large boost in provision.

The purpose of the Law is to regulate the basic conditions that shall guarantee equity in the exercise of the subjective citizen right to the promotion of personal autonomy and care for dependent persons.

The law offers a definition of dependency as the permanent state in which persons that for reasons derived from age, illness or disability and linked to the lack or loss of physical, mental, intellectual or sensorial autonomy require the care of another person/other people or significant help in order to perform basic activities of daily living or, in the case of people with mental disabilities or illness, other support for personal autonomy.

The dependency care benefits may be either services or financial benefits. Services are : for the prevention of situations of dependency and for the promotion of personal autonomy, personal alert system, home help service (housekeeping tasks, personal care), day and night centre service, residential care service (residence for dependent older persons, centre offering care for dependent persons according to the various types of disability).

Financial benefits are : benefit linked to service, benefit for care in the family setting and support for non professional carers and benefit for personal assistance.

The situation of dependency shall be classified in the following degrees : a) Degree I.Moderate dependency : when the person needs help in order to perform various basic activities of daily living, at least once a day or when the person needs intermittent or limited support for his/her personal autonomy. b) Degree II.Severe dependency : when the persons needs help in order to perform various basic activities of daily living two or three times a day, but he/she does not want the permanent support of a carer or when he/she needs extensive support for his/her personal autonomy. c)Degree III.Mayor dependency : when the person needs help in order to perform various basic activities of daily living several times a day, or, due to his/her total loss of physical, intellectual or sensorial autonomy, he/she needs the indispensable and continuous support for his/her personal autonomy.

The Autonomy and Dependency Care System (SAAD) guarantees the basic conditions and common content to which the Law refers. The instrument for articulating the System is the Territorial Council of the Autonomy and Dependency Care System. It is formed by the Ministry of Education, Social Policy and Sport and all the Autonomous Communities. The levels of protection in the system are : a) the minimum level established by the Central State Administration b) the level of protection that is agreed upon between the Central State Administration and the Administration of each of the Autonomous Communities c) Any additional level of protection that may be established by each Autonomous Community.

Local Entities shall participate in the management of the services of care for dependent persons, in accordance with the regulation of their respective Autonomous Communities. Also may participate in the Territorial Council in the form and according to the conditions stipulated by the Council itself.

Sources : European Commission
Ministry of Education, Social Policy and Sport